Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service/Concurrent)	Determinations must be made five (5) business days from the Plan or Delegate's receipt of information reasonably necessary to make the determination, and no later than of 14 calendar days from when the request was received. **The Plan or Delegate may not extend the deadlines for integrated organization determinations.**	**Provider:** The written notification must be sent to the Provider within 24 hours of the decision, not to exceed 14 calendar days after receipt of the request. **Member:** The written notification must be sent to the Member within two (2) business days of the decision, not to exceed 14 calendar days after the receipt of the request.
Expedited Initial Organization Determination **-** If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The fourteen (14) day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, give the member prompt (within seventy-two (72) hours) oral notice of the denial of expedited status including the member's rights followed by written notice within three (3) calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the five(5)- business day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.

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Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination (Pre-Service/Concurrent)	Determinations must be made as expeditiously as the Member's health condition requires, no later than 72 hours from when the Plan or Delegate received the request (includes weekends & holidays). **The Plan or Delegate may not extend the deadlines for integrated organization determinations.**	**Provider:** The written notification must be sent to the Provider within 24 hours of the decision, not to exceed 72 hours from when the request was received. **Member:** The written notification must be sent to the Member no later than 72 from when the request was received. ▪ **Approvals** – Oral or written notice must be given to member and provider within seventy-two (72) hours of receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider within seventy-two (72) hours of receipt of request. ▪ **Denials** – When oral notice is given, it must occur within seventy-two (72) hours of receipt of request and must be followed by written notice within three (3) calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within seventy-two (72) hours of receipt of request. Use Coverage Decision Letter – 30 Day Appeal template for written notification of a denial decision.

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Type of Request	Decision	Notification Timeframes
Standard Initial Determination for Part B Drugs	Determinations must be made as expeditiously as the Member's health condition requires, no later than 72 hours from when the Plan or Delegate received the request(including weekends and holidays).. **The Plan or Delegate may not extend the deadlines for integrated organization determinations.**	**Provider:** The written notification must be sent to the Provider within 24 hours of the decision, not to exceed 72 hours from when the request was received. **Member:** The written notification must be sent to the Member no later than 72 hours from when the request was received. Favorable, Partially Favorable or Adverse Decision: – Provide written notification to the Member and Provider of the decision as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours (including weekends and holidays) after receipt of a Standard request. – If the plan initially provides verbal notification of its decision, it must deliver written confirmation of its decision within three (3) calendar days of the verbal notification. – Use Coverage Decision Letter Part B – 7 Day Appeal template for written notification of a denial decision.

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Type of Request	Decision	Notification Timeframes
Expedited Initial Determination for Part B Drugs	Determinations must be made as expeditiously as the Member's health condition requires, no later than 24 hours from when the Plan or Delegate received the request (including weekends and holidays). **The Plan or Delegate may not extend the deadlines for integrated organizational decisions.**	**Provider:** The written notification must be sent to the Provider within 24 hours of the decision, not to exceed 24 hours from when the request was received. **Member:** The written notification to the Member must be sent no later than 24 hours from when the request was received. Favorable, Partially Favorable or Adverse Decision: – Provide written notification to the Member and Provider of the decision as expeditiously as the Member's health condition requires, but no later than twenty-four (24) hours (including weekends and holidays) after receipt of an Expedited request. – If the plan initially provides verbal notification of its decision, it may deliver written confirmation of its decision within three (3) calendar days of the verbal notification. – Use Coverage Decision Letter Part B – 7 Day Appeal template for written notification of a denial decision.
Post-Service Standard	**Post Service** determinations (UM decisions) are to be made within five (5) business days from the plan's receipt of information reasonably necessary to make the determination and no later than fourteen (14) calendar days from when it receives the request.	**Provider –** Written notification shall be communicated within 24 hours of the decision**.** **Member –** Written notification to the enrollee must happen within 2 business days from the date of the decision, not to exceed 14 calendar days from when the request was received.

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices **(Concurrent)**	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within two (2) calendar days of admission to a hospital inpatient setting. 2) not more than two (2) calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a Member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).	Hospitals must issue the IM within two (2) calendar days of admission, obtain the signature of the Member or their authorized representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than two (2) calendar days prior to discharge from an inpatient hospital. ▪ NOTE: Follow up copy of IM is not required: ▪ If initial delivery and signing of the IM took place within two (2) calendar days of discharge. ▪ When Member is being transferred from inpatient to inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, Member must be given adequate time (at least several hours) to consider their right to request a QIO review.	Upon notification by the QIO that a Member or their authorized representative has requested an appeal, the Health Plan or delegate must issue the DND to both the Member and QIO as soon as possible but no later than noon of the day after notification by the QIO. The DND must include: ▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. ▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the Member may obtain a copy of the Medicare policy from the MA organization. ▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. ▪ Facts specific to the Member and relevant to the coverage determination sufficient to advise the Member of the applicability of the coverage rule or policy to the member's case. ▪ Any other information required by CMS.

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Termination of Provider Services: ▪ **Skilled Nursing Facility (SNF)** ▪ **Home Health Agency (HHA)** ▪ **Comprehensive Outpatient Rehabilitation Facility (CORF)** NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or two (2) visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services **OR** ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the Member or their authorized representative. ▪ The NOMNC must be delivered no later than two (2) calendar days or two (2) visits prior to the proposed termination of services and must include: Member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is two (2) days or less, give notice on admission. **Note**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	Upon notification by the Quality Improvement Organization (QIO) that a Member or authorized representative has requested an appeal: The Health Plan or delegate must issue the DENC to both the QIO and Member no later than close of business of the day the QIO notifies the Health Plan of the appeal.